toma of the right ovary, which was tapped through the abdominal wall, a fistula remaining through which fluid continued to escape for several days. Three months later ovariotomy was performed, an adherent suppurating cyst being removed. At the time of the operation slight induration was noted at the site of the puncture. A year later the patient returned with a fistulous opening at this point, discharging offensive pus. The operation for its closure showed that a colloid growth had developed, which communicated with the interior of the gut, so that intestinal sutures were necessary. The patient made a good recovery. The writer calls attenton to the fact that while implantation metastases are common in connection with malignant ovarian cysts, and cases have been reported following the removal of colloid growths, this is the only one to his knowledge in which all the layers of the abdominal wall have been involved and the disease has extended through the intestine. It possesses importance in its bearing upon the mode of implantation of such neoplasms.

Freund's Operation.—KÜSTNER (*Ibid.*) reports sixteen cases with four deaths. The indications were: Unusual size of the uterus (especially complication with pregnancy or fibroids), narrowness of the vagina, marked friability of the cancerous cervix, and firm adhesions, which in one instance necessitated resection of the intestine, and in another of the bladder. This method can, of course, not be substituted for the vaginal, on account of the higher mortality, Freund's being being 31.6 per cent., while the best statistics (those of Zweifel and Redner), based on much larger series of cases, was 25 per cent. The dangers are due not to abdominal extirpation of the uterus *per se*, *i. e.*, to shock, hemorrhage, or ligation of the ureter, as originally pointed out by Freund, nor to the greater technical difficulties of the method, but to the risk of sepsis, especially in cancer of the uterine body, where infection is often present before operation, as shown by the existing fever. The treatment of the wound is, therefore, of vital importance. The writer had two deaths out of five cases in which the peritoneal cavity was closed without drainage, and two out of four in which vaginal drainage was employed. In seven, in which the Mikulicz tampon was used, however, there were no deaths, hence the inference that the latter is more effectual in preventing the escape of pathogenic micro-organisms into the general cavity.

Extirpation of the Cancerous Uterus with the Cautery.—MACKENRODT (*Ibid.*) emphasizes the difference in technique between vaginal extirpation of the cancerous and non-cancerous uterus. In the latter case the operation is simplified by the fact that the surgeon can keep close to the organ, thereby diminishing the amount of hemorharge and running less risk of injuring the surrounding tissues. In operating for malignant disease, however, the incision through the vaginal fornix must be as remote as possible from the cancerous cervix, while the risk of secondary infection is great. During the past two years and a half the writer has used the cautery exclusively for separating the uterine attachments, with the result that during that period he has not observed a single case of recurrence in the cicatrix, and only one patient has died, from metastasis in the stomach. He at first used the Paquelin, but has abandoned it for the acutal cautery, which he has employed in thirty cases.

In order to avoid delay he has three cautery irons, which can be raised to a glowing heat in a minute by means of a gas-burner fitted with a blow-pipe, so that as fast as one iron cools another is ready. There is some danger of injuring surrounding parts, but with practice this can be certainly avoided. While the immediate mortality is somewhat higher than by other methods—it is far less than that of abdominal extirpation—the results as regards freedom from recurrence are such that he confidently believes that "igni-extirpation" will be the operation of the future for the removal of cancerous growths in all localities, even in the rectum.

The Stump After Salpingectomy.—RIES (*Ibid.*), in three secondary operations upon patients whose tubes had been removed at previous operations, found the stump of the tube open in each instance at the distal end, and lined with the usual cylindrical epithelium. This would seem to explain cases of secondary infection through the uterus, either soon after operation, or later, as well as the few reported cases of pregnancy after double salpingectomy. This fact might also serve as an argument for removing the uterus with the tubes in infectious cases.

Intrauterine Injections.—DÖDERLEIN (*Ibid.*) reports the results of experimental injections of methyl-violet, iodine, and chloride of zinc solutions in six cases in which he was about to perform total extirpation of the uterus. The usual cautions were employed—thorough dilatation of the cervical canal, moderate force, and the maintenance of a return current, yet in all but one instance (a case of endometritis fungosa) the fluid entered the tubes and was forced into the peritoneal cavity. The writer infers that the result of these experiments throws considerable light upon the question of tubal menstruation and the extension of gonorrhœal infection. It is unnecessary, he says, to add that the fact of this perviousness of the tubes fluids should lead to the greatest care in regard to intrauterine therapeusis.

Elastic Tissue in the Fallopian Tubes.—BUCHSTAB (*Centralblatt für Gynäkologie*, No. 28, 1897), from a careful study of 102 specimens of normal and diseased tubes removed from children and women, arrives at the following conclusions: 1. Until the end of the first year elastic tissue is found only in the peritoneal and subserous coats of the tube around the vessels; 2. Between the ages of three and seven this tissue becomes thicker, especially in the neighborhood of the vessels, and fibres are seen in the muscular layers. A few delicate fibres appear in the submucosa; 3. In the tubes of girls between twelve and thirteen years of age, this tissue is well developed, the vessels being surrounded by a dense network. The muscularis mucosæ contains a small quantity, but it is absent from the mucosa; 4. Between fourteen and fifteen there is a great increase in the amount of elastic tissue throughout the different layers, and for the first time delicate fibres are observed in the mucosa; 5. In women between twenty-one and forty-five this tissue reaches its full development, while after the climacteric it begins to atrophy, reaching its minimum at the age of fifty-five years; 6. In the senile tube elastic tissue is found only in the serosa and superficial muscular layer; 7. There is a notable increase in hydro- and pyosalpinx, so that in some specimens it formed